

## Life Settlement Application

(Please fill out completely)

### Policy Owner's Data

Name of Owner: \_\_\_\_\_

If the owner is not a natural person, please indicate if owner is a Trust or LLC: (Trust) (LLC)

Date of Trust or Corporate Resolution: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number or TIN Numbers: \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

State of Legal Residency: \_\_\_\_\_ Country: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/19\_\_\_\_ Place of Birth: \_\_\_\_\_ Sex: (Male) (Female)

Drivers License: State: \_\_\_\_\_ Number: \_\_\_\_\_

### Insured's Data

Name of Insured: \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

State of Legal Residency: \_\_\_\_\_ Country: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/19\_\_\_\_ Place of Birth: \_\_\_\_\_ Sex: (Male) (Female)

Drivers License: State: \_\_\_\_\_ Number: \_\_\_\_\_

Social Security Number: \_\_\_\_/\_\_\_\_/\_\_\_\_

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Send Completed Application to:  
10505 Wayzata Blvd, Suite 1000 • Minnetonka, MN 55305  
Phone: 952-903-9800 x840 • Fax: 952-516-5600

**Second Insured's Data (if applicable)**

Name of Insured: \_\_\_\_\_

Current Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

State of Legal Residency: \_\_\_\_\_ Country: \_\_\_\_\_ Phone: (\_\_\_\_\_) \_\_\_\_\_

Date of Birth: \_\_\_/\_\_\_/19\_\_\_ Place of Birth: \_\_\_\_\_ Sex: (Male) (Female)

Drivers License: State: \_\_\_\_\_ Number: \_\_\_\_\_

Social Security Number: \_\_\_/\_\_\_/\_\_\_\_\_

**Life Insurance Policy Information – (Please include a copy of the policy with application)**

Name of Insurance Company: \_\_\_\_\_

Policy Number: \_\_\_\_\_ Death Benefit/Face Amount: \$ \_\_\_\_\_

Date policy was issued: \_\_\_/\_\_\_/\_\_\_ Policy date (if different than Issue date): \_\_\_/\_\_\_/\_\_\_

Amount of Premium: \$ \_\_\_\_\_ How frequently paid? (Annually) (Semi-Annually) (Quarterly) (Monthly)

When was the last premiums paid? \_\_\_/\_\_\_/\_\_\_ Amount paid? \$ \_\_\_\_\_

Total cumulative premiums paid to date: \$ \_\_\_\_\_

Current Account Value: \$ \_\_\_\_\_ Cash Value: \$ \_\_\_\_\_ Date accurate as of: \_\_\_/\_\_\_/\_\_\_

Do you have a loan against the policy? (Yes) (No) Current loan amount: \$ \_\_\_\_\_

Type of policy: (Universal Life) (Term) (Whole Life) (Variable Life) (Survivorship) (FEGLI) (Other)

Has this policy ever lapsed? (Yes) (No) If yes, When? \_\_\_/\_\_\_/\_\_\_ Reinstatement date: \_\_\_/\_\_\_/\_\_\_

Is this policy currently in a grace period (i.e., premiums overdue)? (Yes) (No)

Has ownership of the Policy changes since the Policy was issued? (Yes) (No)

If yes, please explain: \_\_\_\_\_

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**Medical History**

Describe your health been over the past five years? \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

When and Why were you last treated by this physician? \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_\_

What treatment was prescribed? \_\_\_\_\_

**List all hospitals, clinics and treatment centers where you have received treatment in the last five years:**

Hospitals/ Clinics:

1. \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

When and Why were you last treated by this physician? \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_\_

2. \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

When and Why were you last treated by this physician? \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_\_

3. \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

When and Why were you last treated by this physician? \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_\_

4. \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_

When and Why were you last treated by this physician? \_\_\_\_/\_\_\_\_/\_\_\_\_ - \_\_\_\_\_

**General Information**

Please indicate if you are currently a party to one or more of the following:

Bankruptcy  Civil Lawsuit  Judgment  Tax Lien  Creditor Lien

Have you ever assigned your policy to anyone (e.g., a Bank or Family member) as collateral for a loan? (YES) (NO)

If yes, please explain status of lien: \_\_\_\_\_

Have you given someone Power of Attorney to handle your financial matters? (YES) (NO)

If yes, name of person with your Power of Attorney: \_\_\_\_\_ Phone: \_\_\_\_\_

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**Terms and Conditions**

I, the applicant and the insured named in this questionnaire, do warrant and represent that all of the information contained in this questionnaire is true and correct to the best of my knowledge. I represent that I have a complete understanding of what a life settlement is. I have a full and complete understanding of the benefits of my life insurance policy. I acknowledge that I am of sound mind and am applying for a life settlement freely and voluntarily, and I am under no duress to do so. It is a crime to knowingly provide false, incomplete or misleading information to an insurance company or a life settlement company for the purpose of defrauding the company(ies). Penalties may include imprisonment, fines and civil damages. LIVING BENEFITS ASSET MANAGEMENT, L.L.C. will report cases of suspected fraud to the appropriate authorities.

_____	_____	____/____/20____
Owner's Signature	Owner's Printed Name	Date
_____	_____	____/____/20____
Owner's Witness Signature	Owner's Witness Printed Name	Date
_____	_____	____/____/20____
Insured's Signature	Insured's Printed Name	Date
_____	_____	____/____/20____
Insured's Witness Signature	Insured's Witness Printed Name	Date
_____	_____	____/____/20____
Second Insured's Signature	Second Insured's Printed Name	Date
_____	_____	____/____/20____
Second Insured's Witness Signature	Second Insured's Witness Printed Name	Date

**Signatures must be witnessed**